

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024117

STATE FILE NUMBER

Registration District No. 1A2

Primary Registration District No. 5555

Registrar's No. 30

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED JUN 24 1963

1. PLACE OF DEATH

a. COUNTY Howell

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN Goldsberry

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION Home

Inside Limits  
Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo. b. COUNTY Howell

c. CITY OR TOWN Mtn. View Inside Limits  
Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location) Rural Route 1  
Reside on Farm  
Yes ☒ No ☐

3. NAME OF DECEASED  
(Type or print)

First Middle Last  
Elza Lee Robinson

4. DATE OF DEATH  
Month Day Year  
June 17 1963

5. SEX  
Male

6. COLOR OR RACE  
W.

7. Married ☒ Never Married ☐  
Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4/9/1899 64  
9. AGE (last birthday) 64  
IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Mechanic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Scuyler Co. Ill  
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME

Emory Robinson

13b. MOTHER'S MAIDEN NAME

Flora Belle Anderson Winnie M. Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)  
No

16. SOCIAL SECURITY NO.

17. INFORMANT Address  
Winnie Robinson Mtn. View, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)

PART III. If deceased was female was  
there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE  
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY  
Hour a.m. p.m.  
Month, Day, Year

20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6-17-63 to 6-17-63 and last saw her alive on 6-17-63  
Death occurred at 9:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
Burial

23b. DATE  
6/21/63

23c. NAME OF CEMETERY OR CREMATORY  
New Salem Cem.

23d. LOCATION (City, town, or county)  
Mtn. View, Mo.

24. FUNERAL DIRECTOR ADDRESS  
Duncan Funeral Home Mtn. View, Mo

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Charles D. Farrant*

Licensed Embalmer No.

5107

P. O. Address

Wm. H. New, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.